Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Elilia Tellez, DC

Respondent Name
Cherokee Insurance Company

MFDR Tracking Number
M4-15-0970-01

Carrier's Austin Representative
Box Number 16

MFDR Date Received
November 20, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "THIS BILL SHOULD PAY AS FOLLOWS:

99456 W5 WP MMI = $350.00
IR – HIP W/ROM = $300.00
99456 RE FIRST EXAM= $500.00
99456 RE SECOND EXAM = $250.00
TTL = $1400.00"

Amount in Dispute: $525.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The original billing from Pacific Billing Services was priced to $0 by our bill review company, Coventry Workers Comp, as the submitted billing was incomplete. Pacific Billing Services failed to provide the required provider's State Billing License Number in the designated box.

A reconsideration request was submitted and processed by Coventry Workers Comp allowing payment for $825.00, which was issued to Pacific Billing Services on 5/30/14…"

Response Submitted by: Cherokee Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 21, 2014	Designated Doctor Examination	$525.00	$525.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for billing and reimbursing Designated Doctor Examinations.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

- 1 – The provider's State Billing License Number is Invalid or was not received. (F262)
- 1 – The amount paid reflects a fee schedule reduction. (P300)
- 3 – The charge for this procedure exceeds the fee schedule allowance. (Z710)

Issues

1. What is the correct MAR for the services in dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204 (j)(3), "The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation indicates that the Designated Doctor performed an evaluation of Maximum Medical Improvement as ordered by the Division. **Therefore, the correct MAR for the examination to determine Maximum Medical Improvement is $350.00.**

   Per 28 Texas Administrative Code §134.204 (j)(4), "The following applies for billing and reimbursement of an IR evaluation. (C)(ii) The MAR for musculoskeletal body areas shall be as follows. (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area." The submitted documentation indicates that the Designated Doctor performed a full physical evaluation with range of motion for the left hip to find the Impairment Rating as ordered by the Division. **Therefore, the correct MAR for the examination to determine Impairment Rating is $300.00.**

   Per 28 Texas Administrative Code §134.204 (k), "The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier 'RE.' **In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500** in accordance with subsection (i) of this section and shall include Division-required reports" [emphasis added].

   Furthermore, 28 Texas Administrative Code §134.204 (i)(2) states, "When multiple examinations under the same specific Division order are performed concurrently under paragraph (1)(C) - (F) of this subsection: (A) the first examination shall be reimbursed at 100 percent of the set fee outlined in subsection (k) of this section; (B) the second examination shall be reimbursed at 50 percent of the set fee outlined in subsection (k) of this section; and (C) subsequent examinations shall be reimbursed at 25 percent of the set fee outlined in subsection (k) of this section." The submitted documentation indicates that the Designated Doctor performed examination to determine Extent of Injury and Return to Work as ordered by the Division. **Therefore, the correct MAR for the examination to determine Extent of Injury is $500.00 and for the examination to determine the injured employee's ability to Return to Work is $250.00**

   The correct MAR for the entire Designated Doctor's Examination is $1400.00.

2. Review of the submitted documentation finds that the requestor billed CPT Code 99456-W5-WP (an examination by a designated doctor to determine MMI/IR) for $650.00. The total allowable, as outlined above is $650.00. The insurance carrier paid $500.00. **Therefore, the requestor is entitled to an additional reimbursement of $150.00 for this service.**

   Review of the submitted documentation finds that the requestor billed CPT Code 99456-W6-RE (an examination by a designated doctor to determine Extent of Injury) for $500.00. The total allowable, as outlined above is $500.00. The insurance carrier paid $250.00. **Therefore, the requestor is entitled to an additional reimbursement of $250.00 for this service.**

   Review of the submitted documentation finds that the requestor billed CPT Code 99456-W8-RE (an examination by a designated doctor to determine Return to Work) for $250.00. The total allowable, as outlined above is $250.00. The insurance carrier paid $125.00. **Therefore, the requestor is entitled to an additional reimbursement of $125.00 for this service.**

   The total recommended reimbursement for the disputed services is $525.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $525.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $525.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		January 29, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.